PREHN DENTAL OFFICE

FREDERICK C. PREHN, D.D.S.

PATIENT REGISTRATION

Date: ___________________________

PATIENT INFORMATION

PATIENT'S NAME_____________________________________NICKNAME_________________MIDDLE INITIAL_____
SEX: M F BIRTHDATE: _________________
SINGLE____MARRIED____SEPARATED____WIDOWED____DIVORCED____
NAME OF SPOUSE: ____
IF PATIENT IS A MINOR, PARENT'S NAME____
ADDRESS____CITY_______________STATE____ZIP__________
HOME PHONE_____________________________E-MAIL__________________________________
PATIENT'S SOCIAL SECURITY #_____________________________
NEAREST RELATIVE NOT LIVING WITH YOU_______________________________________PHONE______________
NEAREST FRIEND NOT LIVING WITH YOU____PHONE______________
WHO MAY WE THANK FOR THIS REFERRAL?____

BILLING INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ____
BILLING NAME____
BILLING ADDRESS____CITY_______________STATE_____ZIP_________

EMPLOYER INFORMATION

PATIENT'S EMPLOYER NAME____BUSINESS PHONE___________
SPOUSE'S EMPLOYER NAME____BUSINESS PHONE___________

DENTAL INSURANCE INFORMATION (PRIMARY)

INSURED NAME______________________________________RELATION______________BIRTHDATE_____________
EMPLOYER PROVIDING COVERAGE____GROUP #________________
INSURANCE COMPANY NAME____SS#_____________________

DENTAL INSURANCE INFORMATION (SECONDARY)

INSURED NAME____RELATION__________BIRTHDATE_____________
EMPLOYER PROVIDING COVERAGE____GROUP #________________
INSURANCE COMPANY NAME____SS#_____________________

MEDICAL INSURANCE INFORMATION

EMPLOYER PROVIDING COVERAGE____GROUP #________________
INSURANCE COMPANY NAME____SS#_____________________

(***PLEASE READ AND SIGN THE BACK OF THIS FORM***)